

(b) By an intern or a resident-in-training in the field of dentistry under a teaching program approved by the Council on Dental Education of the American Dental Association; or

(c) By an intern or a resident-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993]

**§ 409.16 Other diagnostic or therapeutic services.**

Diagnostic or therapeutic services other than those provided for in §§ 409.12, 409.13, and 409.14 are considered as inpatient hospital or inpatient CAH services if—

(a) They are furnished by the hospital or CAH, or by others under arrangements made by the hospital or CAH;

(b) Billing for those services is through the hospital or CAH; and

(c) The services are of a kind ordinarily furnished to inpatients either by the hospital or CAH or under arrangements made by the hospital or CAH.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993]

**§ 409.18 Services related to kidney transplantations.**

(a) *Kidney transplants.* Medicare pays for kidney transplantation surgery only if performed in a renal transplantation center approved under subpart U of part 405 of this chapter.

(b) *Services in connection with kidney donations.* Medicare pays for services related to the evaluation or preparation of a potential or actual donor, to the donation of the kidney, or to post-operative recovery services directly related to the kidney donation—

(1) If the kidney is intended for an individual who has ESRD and is entitled to Medicare benefits or can be expected to become so entitled within a reasonable time; and

(2) Regardless of whether the donor is entitled to Medicare.

**§ 409.19 Services related to cardiac pacemakers and pacemaker leads.**

(a) *Requirement.* (1) Providers that request or receive Medicare payment for

the implantation, removal, or replacement of permanent cardiac pacemakers and pacemaker leads must submit to HCFA the information required for the pacemaker registry.

(2) The required information is set forth under 21 CFR part 805 of the FDA regulations and must be submitted in accordance with general instructions issued by HCFA.

(b) *Denial of payment.* If HCFA finds that a provider has failed to comply with paragraph (a) of this section, HCFA denies payment for the implantation, removal, or replacement of any permanent cardiac pacemaker or pacemaker lead, effective 45 days after sending the provider written notice in accordance with paragraph (c) of this section.

(c) *Notice of denial of payment.* The notice of denial of payment—

(1) States the reasons for the determination;

(2) Grants the provider 45 days from the date of the notice to submit the information or evidence showing that the determination is in error; and

(3) Informs the provider of its right to hearing.

(d) *Right to hearing.* If the denial of payment determination goes into effect at the expiration of the 45-day period, it constitutes an “initial determination” subject to administrative and judicial review under part 498 of this chapter.

[56 FR 8840, Mar. 1, 1991; 56 FR 23022, May 20, 1991]

**Subpart C—Posthospital SNF Care**

**§ 409.20 Coverage of services.**

(a) *Included services.* Subject to the conditions and limitations set forth in this subpart and subpart D of this part, “posthospital SNF care” means the following services furnished to an inpatient of a participating SNF, or of a participating hospital or critical access hospital (CAH) that has a swing-bed approval:

(1) Nursing care provided by or under the supervision of a registered professional nurse.

(2) Bed and board in connection with the furnishing of that nursing care.

(3) Physical, occupational, or speech therapy.

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- (4) Medical social services.
- (5) Drugs, biologicals, supplies, appliances, and equipment.
- (6) Services furnished by a hospital with which the SNF has a transfer agreement in effect under § 483.75(n) of this chapter.
- (7) Other services that are generally provided by (or under arrangements made by) SNFs.

(b) *Excluded services*—(1) *Services that are not considered inpatient hospital services.* No service is included as posthospital SNF care if it would not be included as an inpatient hospital service under §§ 409.11 through 409.18.

(2) *Services not generally provided by (or under arrangements made by) SNFs.* Except as specifically listed in §§ 409.21 through 409.27, only those services generally provided by (or under arrangements made by) SNFs are considered as posthospital SNF care. For example, a type of medical or surgical procedure that is ordinarily performed only on an inpatient basis in a hospital is not included as “posthospital SNF care,” because such procedures are not generally provided by (or under arrangements made by) SNFs.

(c) *Terminology.* In §§ 409.22 through 409.36—

(1) The terms *SNF* and *swing-bed hospital* are used when the context applies to the particular facility.

(2) The term *facility* is used to mean both SNFs and swing-bed hospitals.

(3) The term “swing-bed hospital” includes a CAH with swing-bed approval under subpart F of part 485 of this chapter.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985; 58 FR 30667, May 26, 1993; 63 FR 26306, May 12, 1998; 64 FR 3648, Jan. 25, 1999; 64 FR 41681, July 30, 1999]

## § 409.21 Nursing care.

(a) *Basic rule.* Medicare pays for nursing care as posthospital SNF care when provided by or under the supervision of a registered professional nurse.

(b) *Exception.* Medicare does not pay for the services of a private duty nurse or attendant. An individual is not considered to be a private duty nurse or attendant if he or she is an SNF employee at the time the services are furnished.

[63 FR 26306, May 12, 1998]

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## § 409.22 Bed and board.

(a) *Semiprivate and ward accommodations.* Except for applicable deductible and coinsurance amounts Medicare Part A pays in full for semiprivate (2 to 4 beds), or ward (5 or more beds) accommodations.

(b) *Private accommodations*—(1) *Conditions for payment in full.* Except for applicable coinsurance amounts, Medicare pays in full for a private room if—

(i) The patient's condition requires him to be isolated;

(ii) The SNF has no semiprivate or ward accommodations; or

(iii) The SNF semiprivate and ward accommodations are fully occupied by other patients, were so occupied at the time the patient was admitted to the SNF for treatment of a condition that required immediate inpatient SNF care, and have been so occupied during the interval.

(2) *Period of payment.* In the situations specified in paragraph (b)(1) (i) and (iii) of this section, Medicare pays for a private room until the patient's condition no longer requires isolation or until semiprivate or ward accommodations are available.

(3) *Conditions for patient's liability.* The facility may charge the patient the difference between its customary charge for the private room furnished and its most prevalent charge for a semiprivate room if:

(i) None of the conditions of paragraph (b)(1) of this section is met, and

(ii) The private room was requested by the patient or a member of the family who, at the time of request was informed what the charge would be.

## § 409.23 Physical, occupational, and speech therapy.

Medicare pays for physical, occupational, or speech therapy as posthospital SNF care if—

(a) It is furnished by the facility or under arrangements made by the facility, and

(b) Billing for the therapy is by or through the facility.

## § 409.24 Medical social services.

Medicare pays for medical social services as posthospital SNF care, including—